King County Mental Health, Chemical Abuse and Dependency Services Division

Substance Abuse Prevention and Treatment Annual Report

2014

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Message From the Substance Abuse Treatment Coordinator

Everyone in the King County behavioral health system has been immersed in work, preparing for integrating mental health and substance use disorder services into a single behavioral health organization. This year's report focuses exclusively on performance data. We recognize all of the amazing programmatic work that has occurred and offer our sincere gratitude to everyone in the community working in partnership with us to develop an integrated system built on whole-person care and the ideals of wellness and recovery.

We hope you find this information valuable.

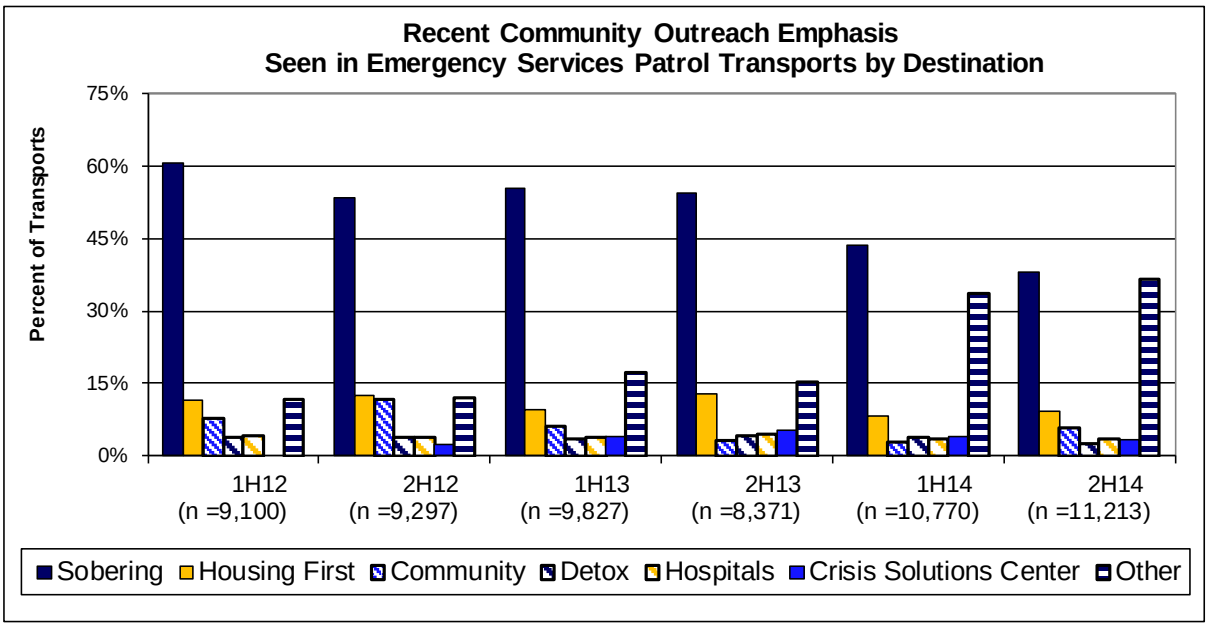
Assistant Division Director, Prevention and Treatment Coordinator

Substance Use Disorder Intervention Programs

Preventing and treating drug abuse and dependency, commonly referred to as substance use disorders (SUD), is consistent with the King County Strategic Plan health and human potential goal of providing opportunities for all communities and individuals to realize their full potential, and fulfills all of the strategic plan objectives aligned with this goal. Data reported here include only data on publicly funded programs managed by the County, and do not include privately funded services, physician office based Suboxone treatment, or residential treatment programs.

Emergency Services Patrol

The main duty of the Emergency Services Patrol (ESP) screeners is to relieve firefighters, police, and medics from caring for chronic alcohol/substance users in need of non-emergency assistance. They do this primarily by transporting individuals to the Dutch Shisler Service Center (DSSC), commonly known as the Sobering Center, or to other safe environments. The screeners also patrol the downtown core, seeking out individuals in need of service. In addition, they transport clients from the sobering service center to other providers. The service operates 24 hours a day, 7 days a week, every day of the year. The chart below shows the number of individuals transported and the destination of each transport by biennial quarter.



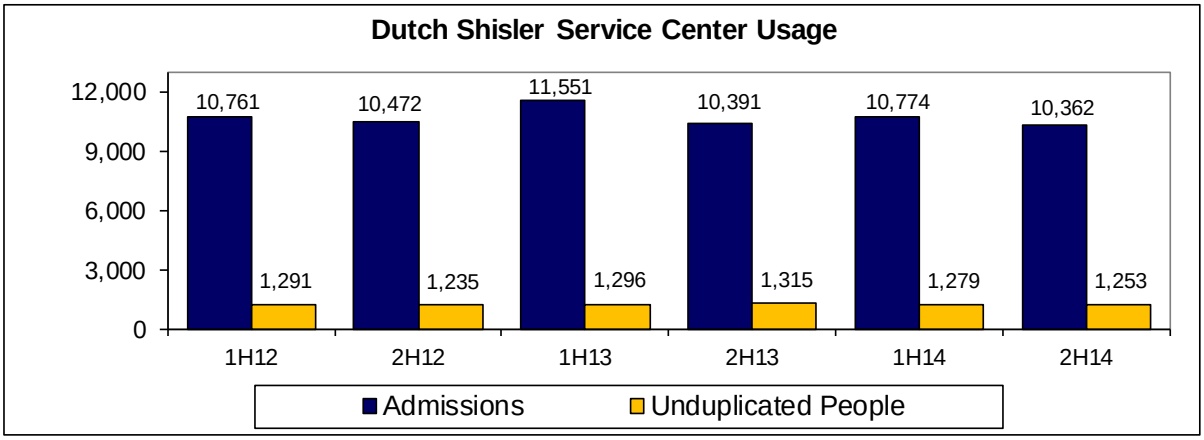
The dramatic increase in the percentage of "Other" transports shown in 2014 reflects an emphasis on community-based outreach to individuals when the ESP teams are not responding to 911 calls. Because these more than doubled in 2014 from 2013, the total transports in 2014 increased by 21%. This report also shows the first two full years of the new transport category for the Crisis Solutions Center (CSC), which opened in mid-2012.

Client-specific demographic data about ESP services are not currently available. The demographic data from DSSC provide a good approximation of ESP client demographics.

Dutch Shisler Service Center

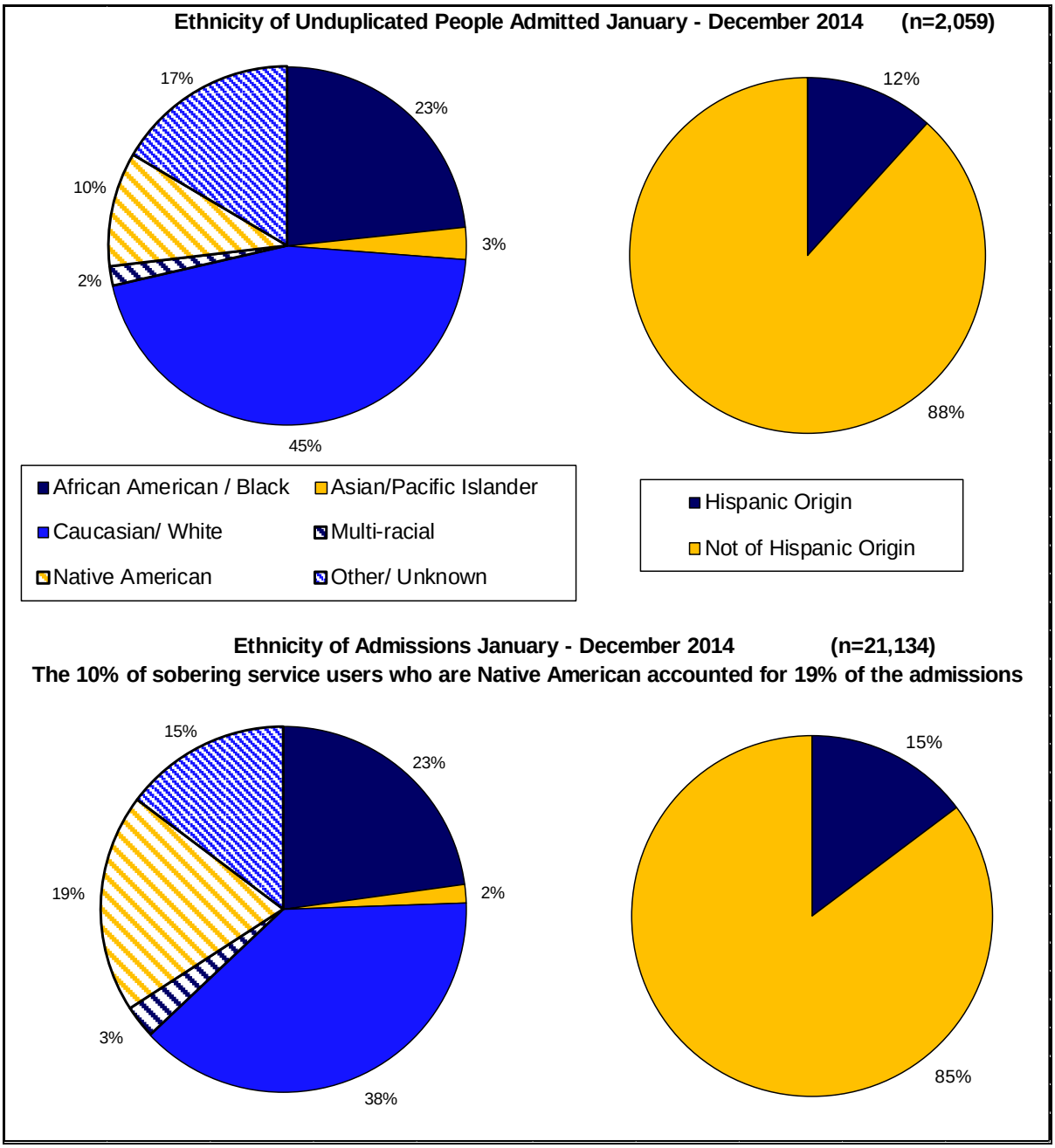
The DSSC serves as a safe and secure place for persons to sleep off the acute effects of intoxication and is an important recovery entry point in King County's recovery-oriented system of care. It serves as a center for clients to access case management services, outpatient chemical dependency treatment, and other assistance to move towards greater self-sufficiency.

The chart below shows the number of admissions to the Dutch Shisler Service Center for sobering services, and the number of unduplicated people who used that service.



A small number of individuals who are high utilizers of DSSC account for the majority of center admissions. In the last biennial quarter, 8.8 percent (110) of the 1,253 people admitted accounted for 64 percent of the total admissions. These 110 individuals averaged 60 admissions each during the six-month period, with a range from 25 to 164 admissions. Frequent users of the center are often involved in multiple systems, such as primary and behavioral health, social services, criminal justice, and housing. These individuals have complex and chronic needs and are generally not served effectively by the high-cost settings, such as emergency departments, they tend to access.

The next charts show the ethnicity of unduplicated people served by DSSC from January through December 2014, as well as the ethnicity of the person for each admission, providing additional information about high users of the DSSC. (See Appendix A for additional details about the ethnicity data).

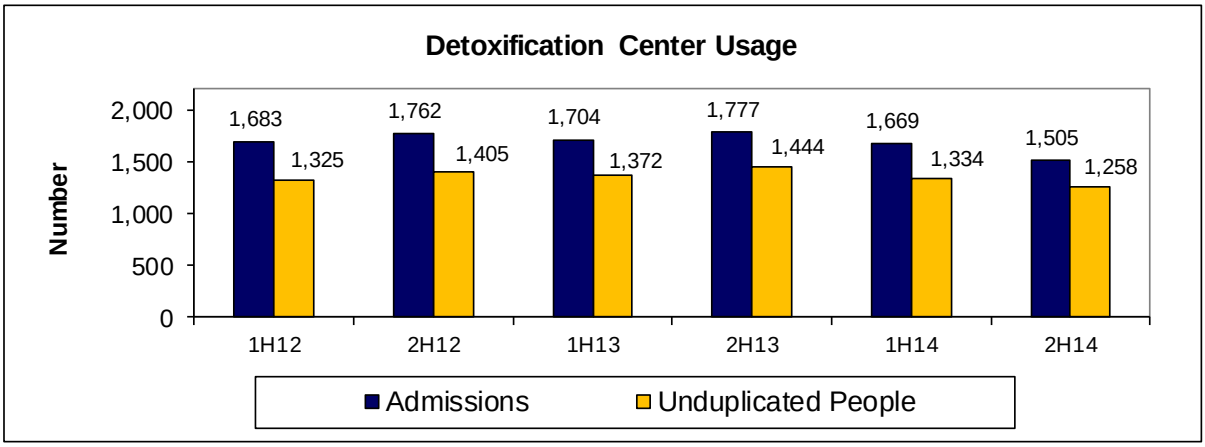


The charts above show disproportionately high use of sobering services by Native Americans. Among the 2,059 people admitted to DSSC anytime in 2014, the percentage who are Native American (10 percent) is much higher than the percentage of Native Americans in either the general population (2 percent) or in any other drug/alcohol program, other than Involuntary Commitment Services (see Summary Data, Demographic Detail). In addition, a disproportionate number of the frequent users of DSSC are Native American: 19 percent of those admitted five times or more in the last biennial quarter were Native American (data not shown), and 19 percent of the 21,134 admissions in 2014, were for Native Americans. This disproportionate frequent use of the center by Native Americans is a long-standing issue, speaking to the need to develop and deliver tailored intervention programs to this group.

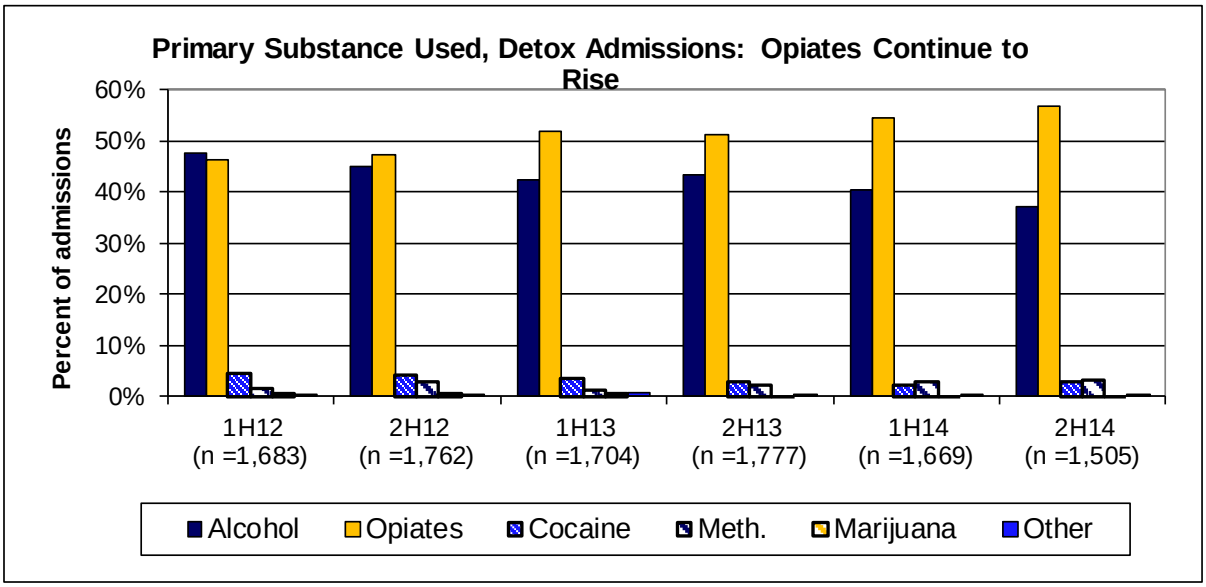
Detoxification Center

Detoxification services are provided to indigent and low-income clients who are withdrawing from alcohol or other drugs. Upon successful completion of detoxification services, clients are referred for ongoing treatment and support.

The chart below shows the number of new admissions to the Detoxification Center during each biennial quarter and the number of unduplicated people admitted.



The following chart shows the primary substance used by people admitted to the Detoxification Center. This is usually, but not always, the substance for which detoxification is needed (see Appendix A for more information).

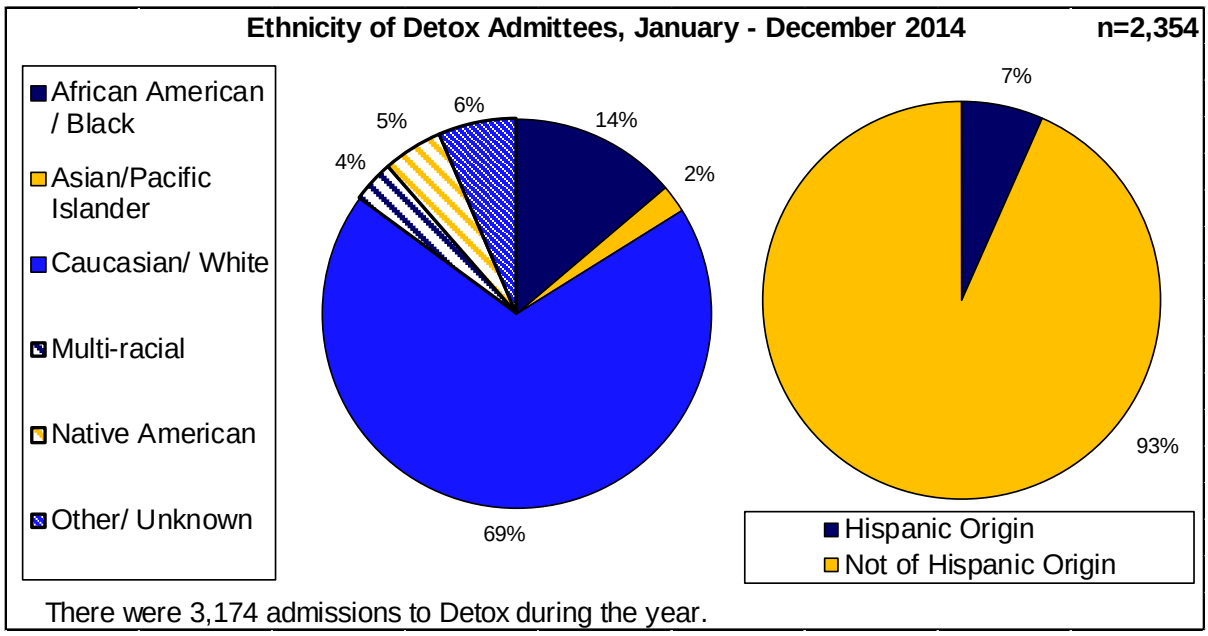


There was a steady increase over the six biennial quarters from 2009 through 2011 (not shown) in the percentage of detoxification clients who indicated opiates as their primary drug used. That increase leveled off in 2012, but resumed in 2013 and 2014. Alcohol went from being the primary substance used for 62 percent of admissions in the first half of 2009 to only 37 percent of admissions in the second half

of 2014. This trend in admission data is consistent with epidemiological trends, statewide and nationally, showing a rise in opiate use.

From the first half of 2008 through the second half of 2011, there was a steady increase in the number and percentage of young adults under 30 years old entering detoxification services. The numbers and percentages of young adults leveled off during 2012, and have remained at higher levels. Among all individuals admitted in 2014, *85 percent of those younger than 30 years old indicated opiates are their primary drug used* compared to 41 percent of those 30 years or older. See the "Program Comparisons" section for more discussion of these differences.

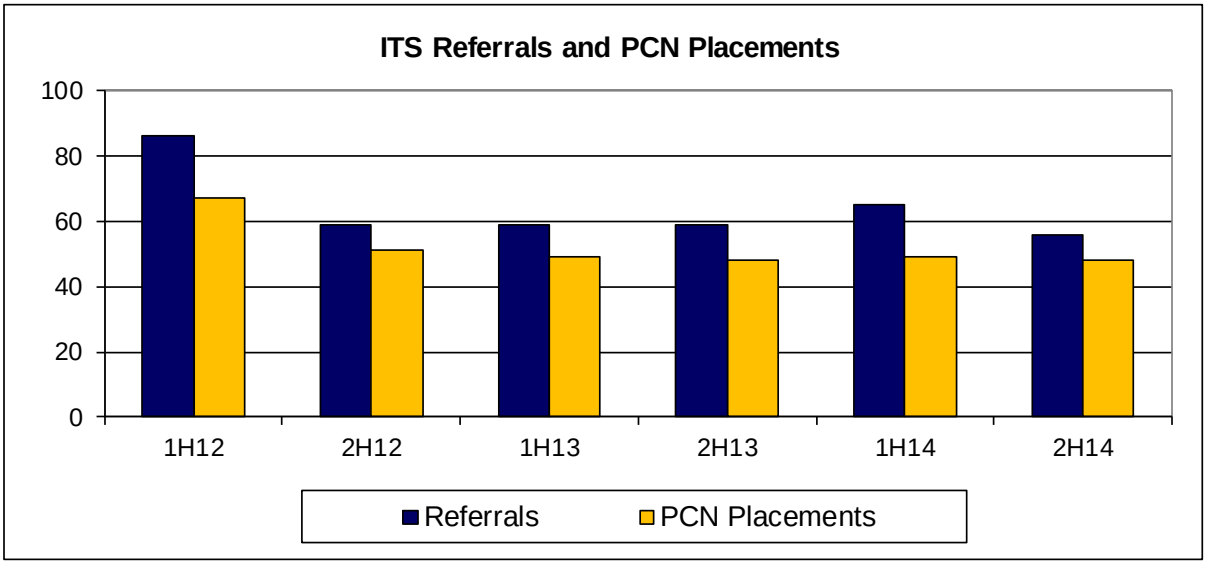
The charts below show the ethnicity of unduplicated people admitted to the Detoxification Center from January through December 2014. Interestingly, white people account for the majority of individuals accessing detoxification services while people of color account for the majority of those accessing Sobering Center support. See Appendix A for additional details.



Involuntary Commitment Services

Involuntary Commitment Services (ICS) include investigation and evaluation of facts to determine whether a person is incapacitated as a result of substance use. If a substance use disorder specialist determines there is reliable evidence to support a finding of incapacity, a petition for commitment can be filed on behalf of the incapacitated person. Courts can then authorize a person to a locked treatment facility for intensive treatment.

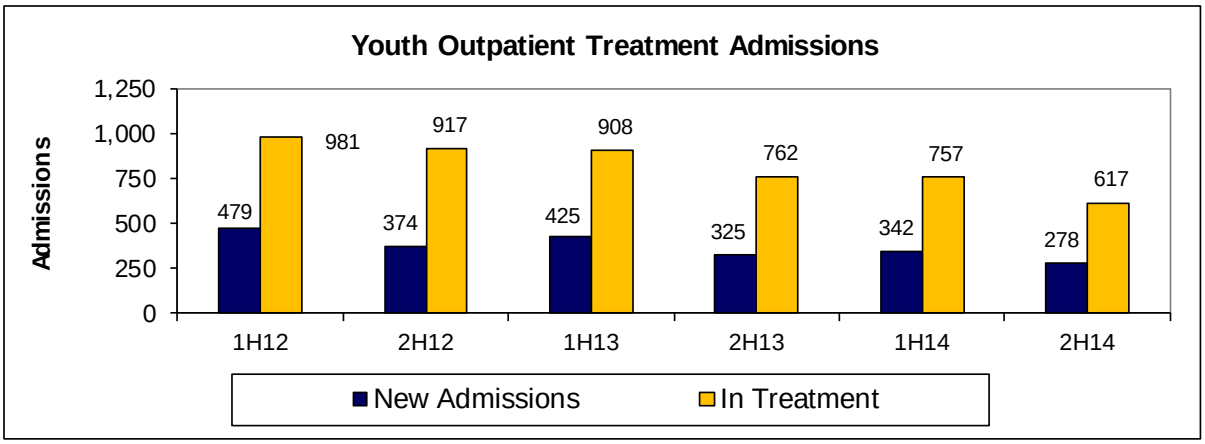
The following chart shows the referrals received by ICS for investigation and the number of commitments that resulted in a placement at Pioneer Center North (PCN) for inpatient treatment.



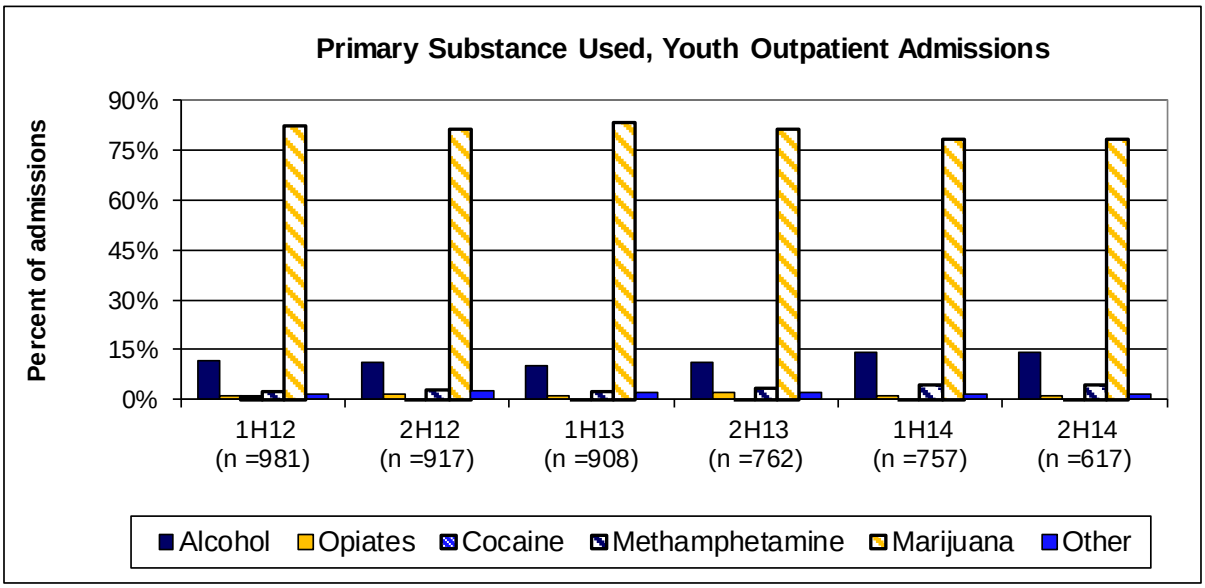
Outpatient Treatment – Youth

Outpatient treatment services for youth are targeted for low-income and indigent youth who are abusing or who are dependent on alcohol and/or other substances. Services include development of sobriety maintenance skills, family therapy or support, case management, and relapse prevention. Services are expected to improve school performance and peer/family relationships, prevent or reduce criminal justice involvement, and to decrease risk factors associated with substance use and abuse.

The following chart shows existing caseloads plus new admissions to outpatient treatment for youth under 18 years old. Both "new admissions," which started during the biennial quarter, and "in treatment" are shown. "In treatment" includes everyone who was admitted any time before the end of the quarter and not discharged by the start of the quarter.

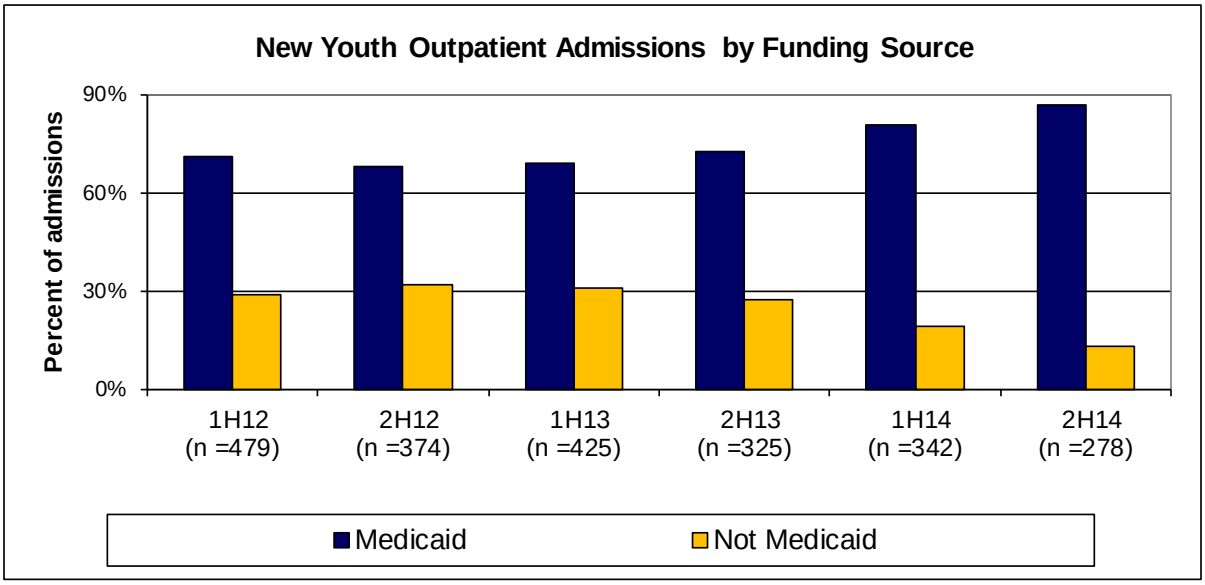


The following chart shows the primary substance used by youth in outpatient treatment.

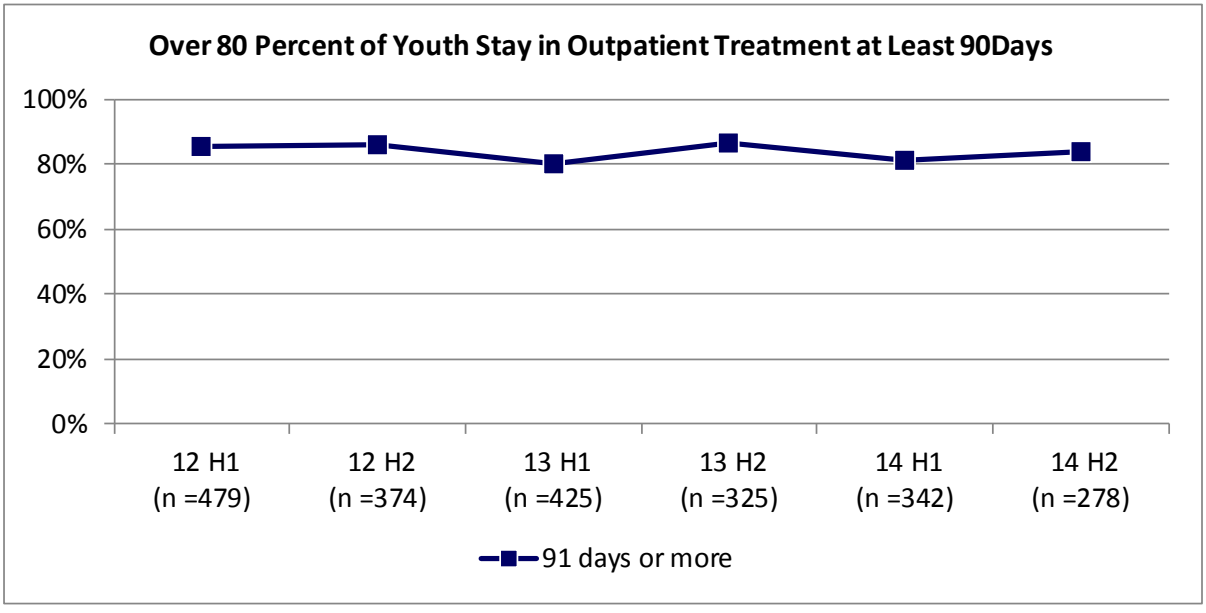


While the most frequently used drug among youth in treatment is marijuana, a significant percentage of youth are using alcohol. A very small number of youth are in treatment for opiate use, which appears to become more problematic for people in their twenties. In addition, opiate use is often treated via other modalities, such as medication-assisted treatment or detoxification.

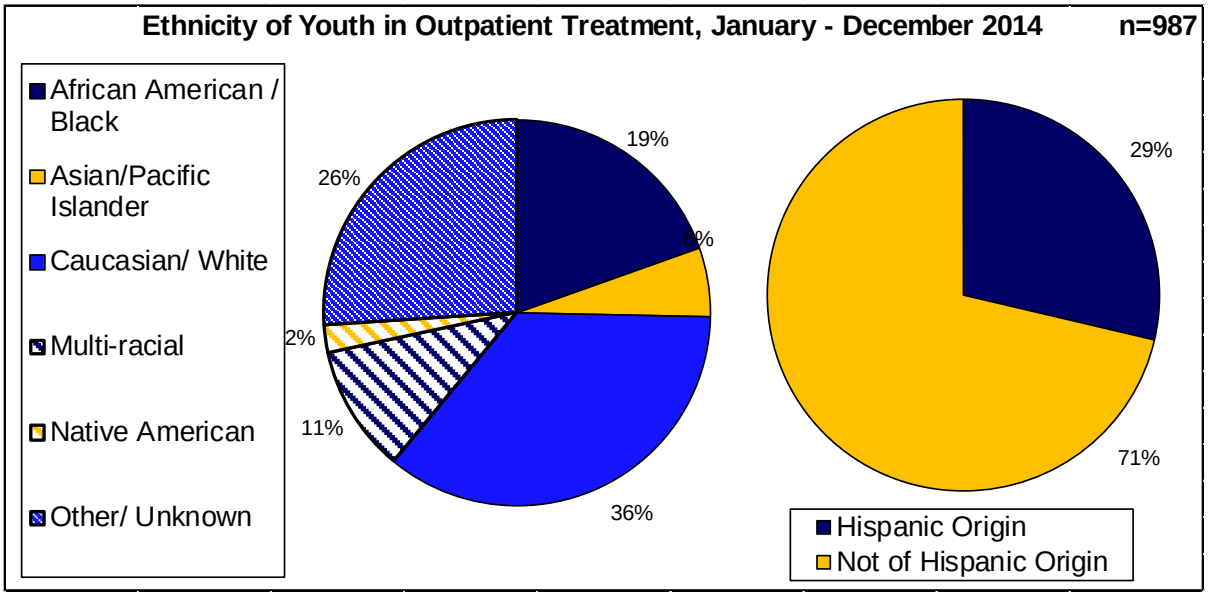
The chart below shows the proportion of newly admitted youth each biennial quarter whose treatment is funded by Medicaid versus other public funding. Although the percentages of youth receiving outpatient treatment funded by Medicaid have increased, the numbers have not; rather the increase in the percentage is because the number of youth in treatment with other public funding have decreased.



In mid-2011, the Washington State Division of Behavioral Health and Recovery (DBHR) dropped a long-standing focus on treatment completion as a key outcome measure and shifted focus to treatment retention starting in 2012. Because research shows that people who remain in treatment for more than 90 days tend to have better outcomes, this report now includes a measure of those who started treatment during each report period and remained in treatment for 91 days or longer. (See Appendix A for details on how the rate is determined.)



The charts below show the ethnicity of unduplicated youth receiving outpatient treatment from January through December 2014. (See Appendix A for additional details.)

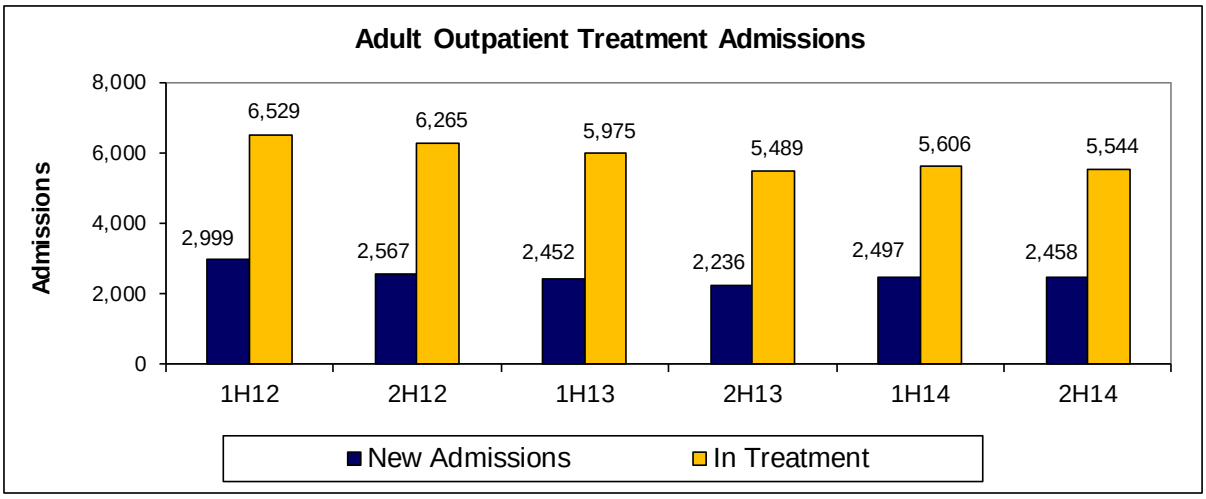


The vast majority of youth who report other/unknown are of Hispanic origin. Among all youth who reported a single ethnic group that was Other (or unknown), about 90 percent also reported some Hispanic origin. About 80 percent of youth who reported some Hispanic origin also reported an ethnic group of Other (or unknown).

Outpatient Treatment – Adult

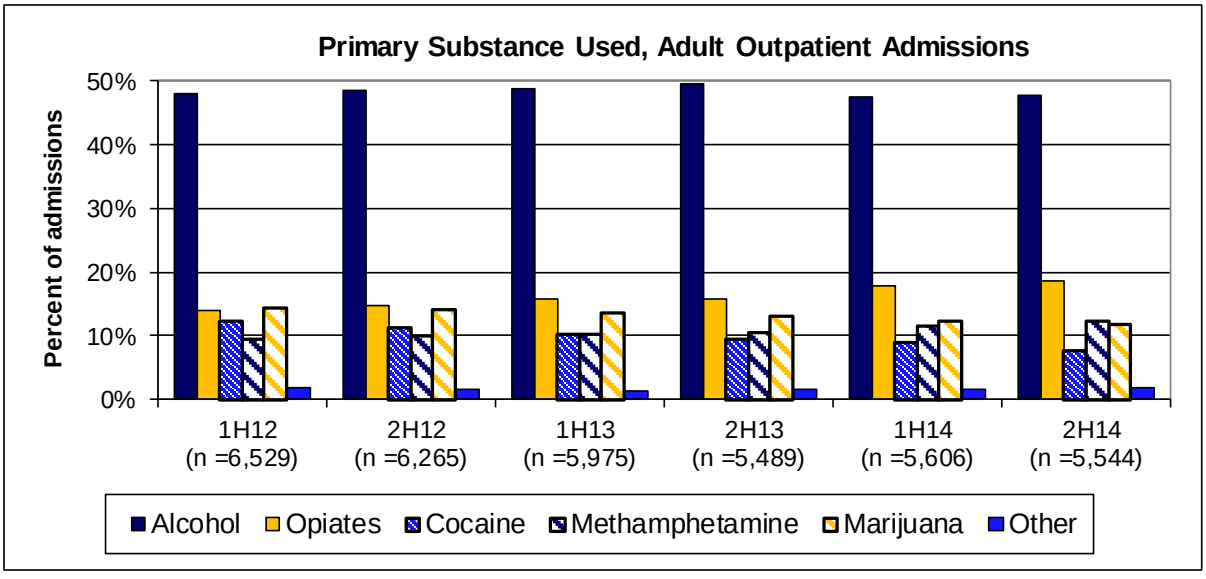
Outpatient treatment services are provided to low-income and indigent adults, 18 years and older, who need treatment to recover from addiction to drugs and/or alcohol. Services are designed to assist clients with achieving and maintaining sobriety and achieving other recovery goals in their lives, and can include individual face-to-face treatment sessions, group treatment, case management, employment support, or other services, including referrals to appropriate agencies.

The following chart shows caseloads and admissions to outpatient treatment for adults, 18 years and older. Both "new admissions" (which started during the biennial quarter) and "in treatment" are shown. "In treatment" includes everyone who was admitted any time before the end of the quarter and not discharged by the start of the quarter.



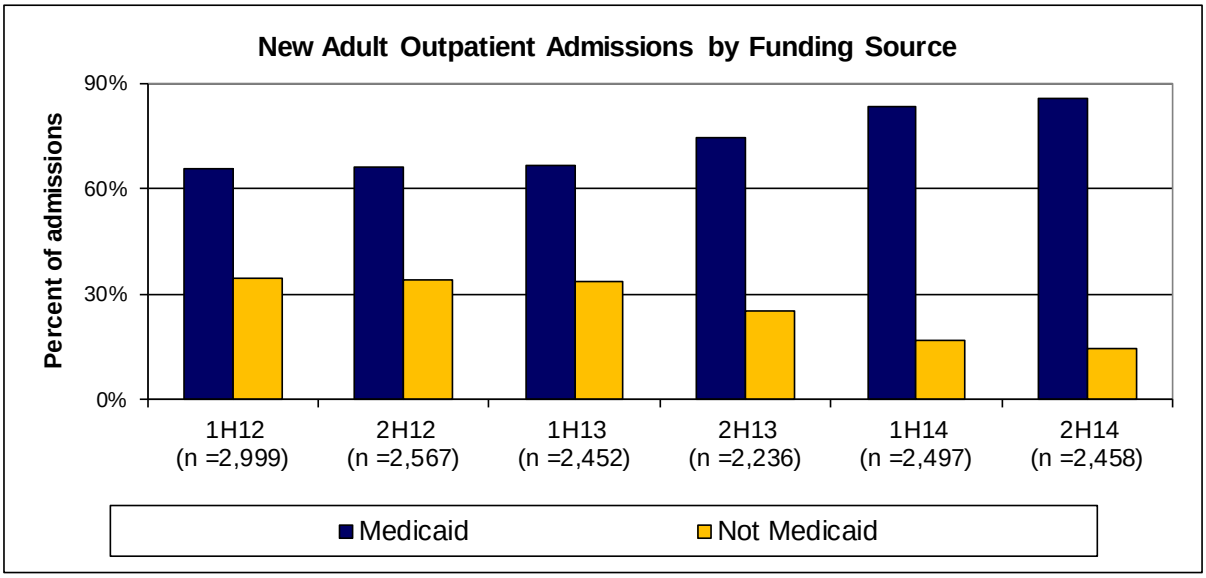
The decreases from 2011 through 2013 in the number of people remaining in treatment reflect decreased state funding available for outpatient treatment for those who do not have Medicaid coverage.

The following chart shows the primary substance used by adults in outpatient treatment.



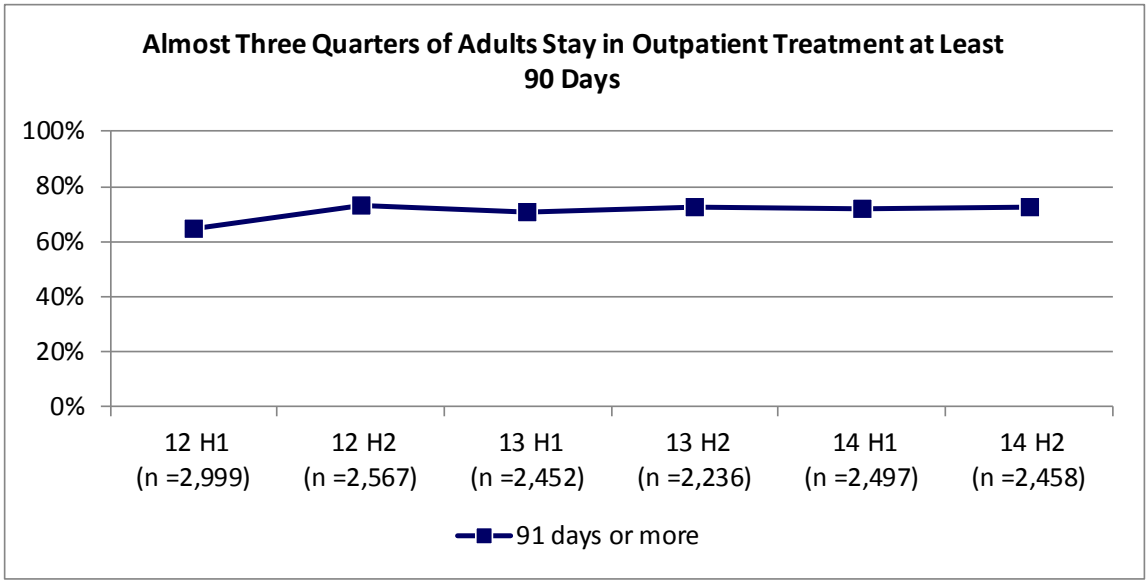
Although the total number of adults in treatment decreased 13 percent between 2012 and 2014, the number in treatment where the primary substance used was opiates increased by 11 percent. Across the quarters in this report, there was a fairly steady increase in the percentage reporting opiates as the primary substance, from 14 percent in the first quarter of 2012 to 19 percent in the second quarter of 2014. Alcohol remained by far the most frequently reported primary substance used.

The following chart shows the proportion of newly admitted adults each biennial quarter whose treatment is funded by Medicaid versus other public funding.

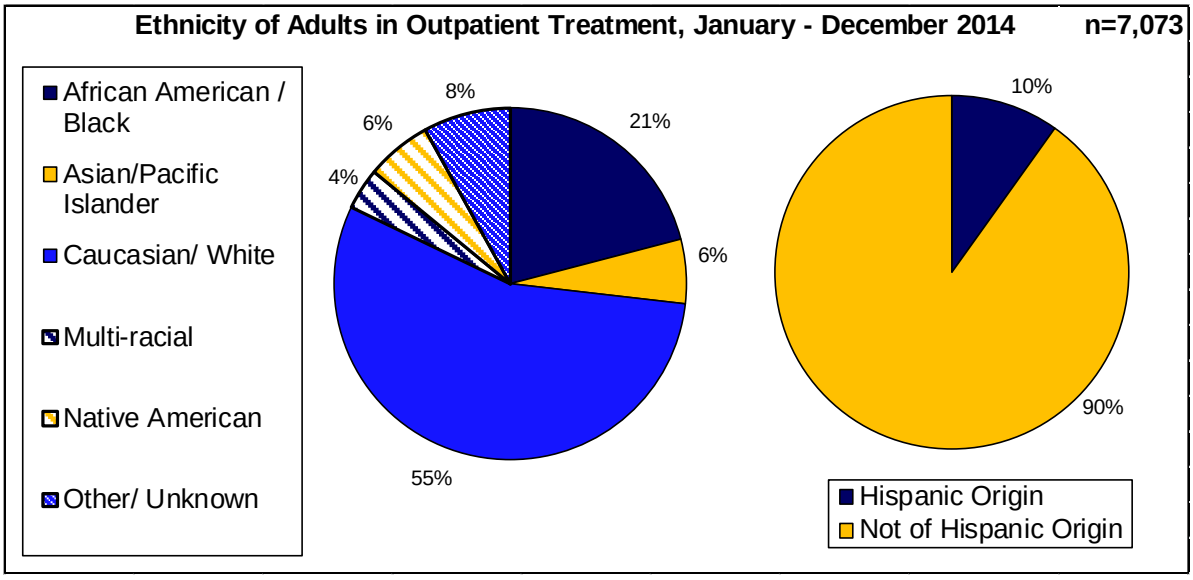


The shift in proportion of Medicaid funded admissions from 66 percent in the first half of 2013 to 74 percent in the second half of 2013 was a function of decreased state resources for individuals who were not eligible for Medicaid. However, the continued increase for Medicaid funded admissions in 2014 to 85 percent resulted from the expansion of Medicaid coverage to many low-income adults due to the Affordable Care Act (ACA).

In mid-2011, DBHR dropped a long-standing focus on treatment completion as a key outcome measure and shifted focus to treatment retention. Because research shows that people who remain in treatment for more than 90 days tend to have better outcomes, this report now includes a measure of those who started treatment during each report period and remained in treatment for 91 days or longer. (See Appendix A for details on how the rate is determined.)



The charts below show the ethnicity of unduplicated adults receiving outpatient treatment from January through December 2014. See Appendix A for additional details.

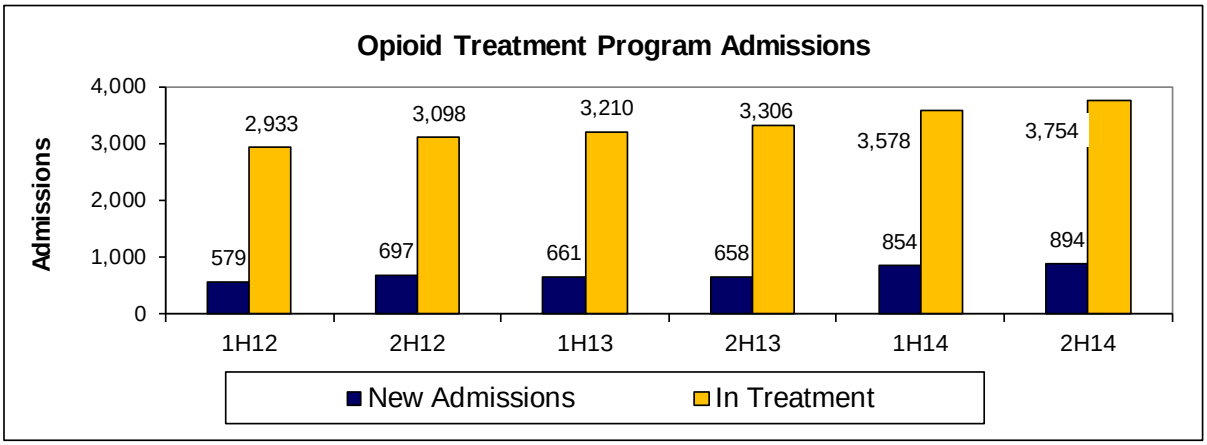


The majority of adults who report other/unknown are of Hispanic origin. Among all adults who reported a single ethnic group that was Other (or unknown), about 75 percent also reported some Hispanic origin. About 60 percent of adults who reported some Hispanic origin also reported an ethnic group of Other (or unknown).

Opioid Treatment Programs

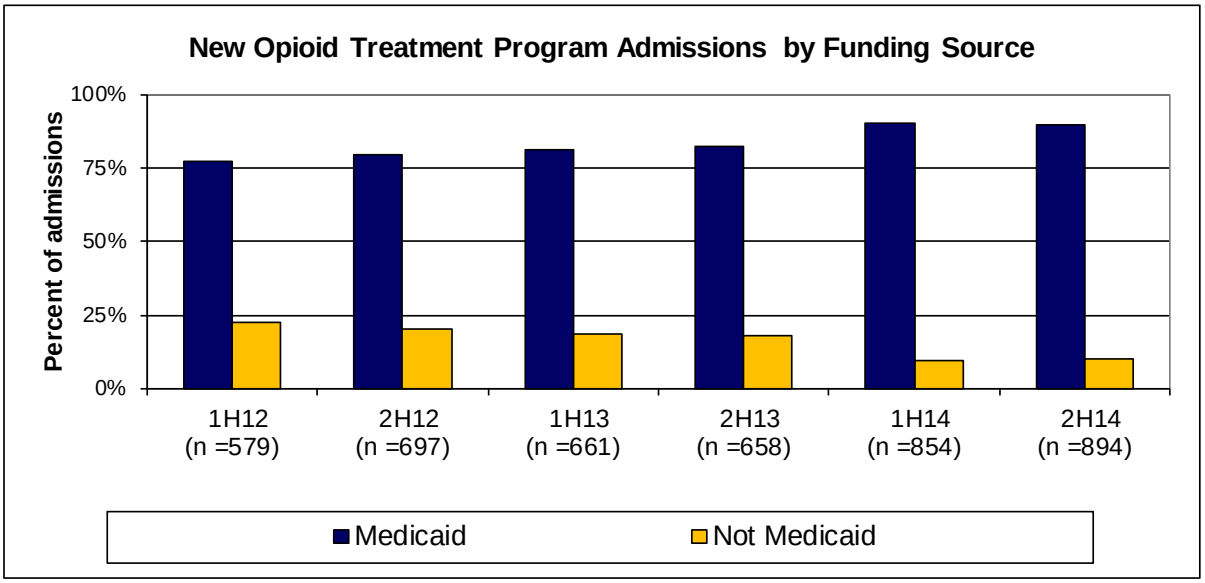
Opioid treatment programs (OTP) provide medically supervised medication-assisted treatment services to individuals addicted to opiates, whether to heroin or prescription opiates. In addition to physical exams and medical monitoring, clinics provide individual and group counseling, medications, urinalysis screening, referral to other health and social services, and patient monitoring.

The chart below shows caseloads and admissions to opioid treatment programs. Both "new admissions," which started during the biennial quarter, and "in treatment" are shown. "In treatment" includes everyone who was admitted any time before the end of the quarter and not discharged by the start of the quarter.



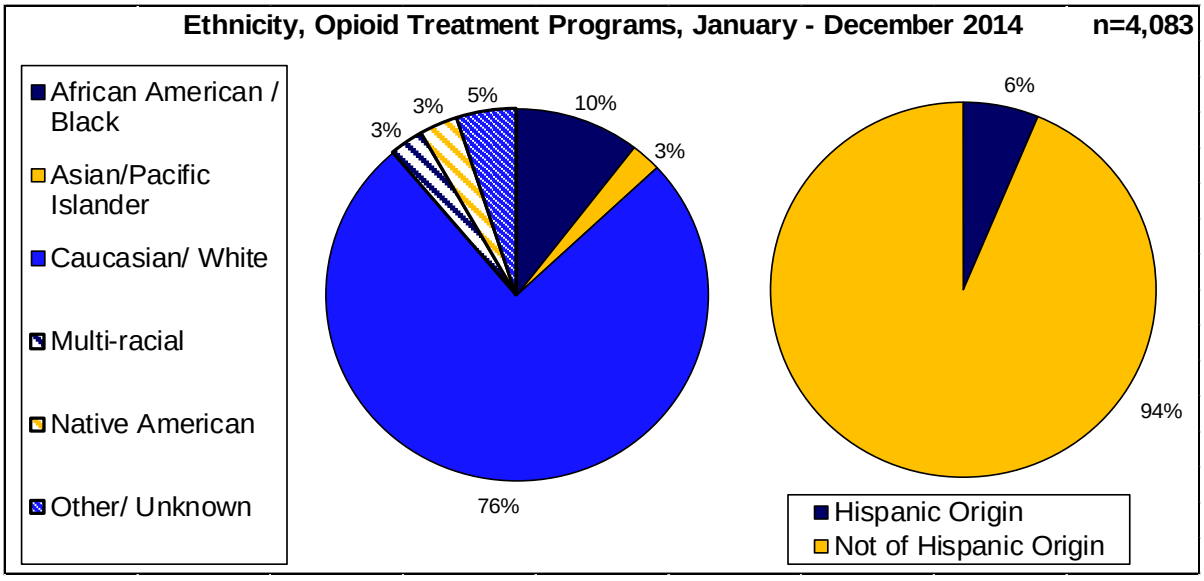
Consistent with the goals of this treatment modality, individuals tend to be retained in medication-assisted treatment for long durations, limiting the availability of new treatment slots. The increase in both new admissions and people in treatment that started during the second half of 2012 reflects increased treatment capacity from the new OTP clinic that opened in Bellevue in July 2012. The County is working with treatment providers to open another new clinic in south King County to continue to address limited capacity and countywide services. It is expected to open in 2016. Trends in treatment admissions have historically been a function of funding availability and service capacity. Demand has exceeded both funding and service resources for years, and individuals needing treatment have been kept on a waiting list. As a result of opening the eastside clinic and Medicaid Expansion, the waiting list was reduced from 300+ people to virtually zero in 2014.

The following chart shows the proportion of newly admitted people each biennial quarter whose opioid treatment is funded by Medicaid versus other public funding.



The impact of Medicaid expansion in 2014 due to the ACA is shown above in the dramatic increase in the percentage of Medicaid funded admissions in 2014, as well as in the overall number of admissions seen in the Opioid Treatment Program Admissions chart.

The following charts show unduplicated people receiving opioid treatment from January through December 2014. See Appendix A for additional details.



Among all who reported a single ethnic group that was Other (or unknown), about 65 percent also reported some Hispanic origin. About 50 percent of those who reported some Hispanic origin also reported an ethnic group of Other (or unknown).

Summary Data

Overview

This section provides summary data from the last calendar year on services provided, dispositions, and demographics of individuals served. It also provides summary data for the last three calendar years for financial revenues and expenditures.

The services data are for the same program areas and measures that were presented graphically in the Programs section. The time period that the data describe is different. Data in this section are for the most recent calendar year, which is the same time period as the last two biennial quarters shown in the charts. See Appendix A for additional details.

The demographic data are broader than the data in the Programs section. The gender, race or ethnic group, and Hispanic origin status of all unduplicated individuals served during the most recent calendar year are reported. This includes all programs except the Emergency Services Patrol.

To provide context, U.S. Census Bureau data for gender and ethnicity in the youth and adult populations in King County that are below the Federal poverty level are shown in addition to the demographic data for each program. Although many people with somewhat higher incomes also qualify for public funding, these data approximate the gender and ethnic mixtures among King County residents who are eligible for publicly funded services. Data for the "Youth Outpatient" programs should be compared to the "Youth" population. All other programs except Prevention serve only adults. (Data Source: U.S. Census Bureau, 2005-2009, American Community Survey, B17001A-I tables.)

The financial data include a financial plan (see page 26) for actuals for 2012, 2013, and 2014, and the expenditures for outpatient treatment services. The financial plan shows the beginning fund balance, revenues received by revenue type, expenditures made by expenditure, and the ending fund balance. The financial plan does not include dollars from the Mental Illness and Drug Dependency (MIDD) Action Plan. The chart at the bottom of the page combines the contracted expenditures for outpatient treatment services from the financial plan with the MIDD expenditures. The chart is broken out by outpatient treatment services for adults and youth, and opioid treatment programs. Total contracted non-Medicaid outpatient services accounted for $17,734,478 in 2012, $17,830,881 in 2013, and $9,709,816 in 2014. The dramatic decrease in 2014 resulted from the expansion of Medicaid funding in 2014, which moved many people from non-Medicaid treatment services paid by King County to Medicaid-covered services, which are currently paid directly from the State to providers.

Medicaid funding is not included in the financial plan figures. Medicaid combines State and Federal funds to pay for treatment services. Funds are set aside from the MHCADSD biennium contract with the State and matched with Federal dollars to be paid by the State directly to provider agencies for treatment services for Medicaid covered individuals. For 2014, the payment reports provided by DBHR show payments of: $9,437,916 for 2012, $9,223,203 for 2013, and $14,658,926 for 2014. This increase of 59% is largely due to Medicaid expansion and the Affordable Care Act.

Services and Dispositions, January – December 2014

	Number	Percent
ESP Transports		
All Destinations	21,983	100%
Sobering	8,963	41%
Housing First	1,941	9%
Street	1,003	5%
Detox	733	3%
Hospitals	812	4%
Crisis Solutions Center	776	4%
Other	7,755	35%
Sobering Center		
Admissions	21,134	
Unduplicated People	2,059	
Detoxification Center		
Admissions	3,174	
Unduplicated People	2,354	
Admissions by drug of choice	3,174	100%
Alcohol	1,235	39%
Opiates	1,759	55%
Cocaine	75	2%
Methamphetamines	94	3%
Marijuana		0%
Other		0%
Involuntary Commitment Services		
Referrals	121	
Unduplicated people	114	
PCN Placements	97	

	Number	Percent
Outpatient Treatment		
Youth		
New admissions	620	
In Treatment	1,035	
Unduplicated people (open)	987	
Open admissions by drug of choice		
Alcohol	134	13%
Opiates	17	2%
Cocaine	2	0%
Methamphetamines	46	4%
Marijuana	821	79%
Other	15	1%
New admissions by Medicaid status		
Medicaid	518	84%
Not Medicaid	102	16%
Treatment retention for admissions during year		
91 days or more	511	82%
Less than 91 days	109	18%
Adult		
New admissions	4,955	
In Treatment	8,064	
Unduplicated people (open)	7,073	
Open admissions by drug of choice		
Alcohol	3,758	47%
Opiates	1,505	19%
Cocaine	660	8%
Methamphetamines	1,015	13%
Marijuana	993	12%
Other	133	2%
New admissions by Medicaid status		
Medicaid	4,182	84%
Not Medicaid	773	16%
Treatment retention for admissions during year		
91 days or more	3,579	72%
Less than 91 days	1,376	28%
Opioid Treatment Programs		
New admissions	1,748	
In Treatment	4,472	
Unduplicated people (open)	4,083	
New admissions by Medicaid status		
Medicaid	1,577	90%
Not Medicaid	171	10%

Program Comparisons

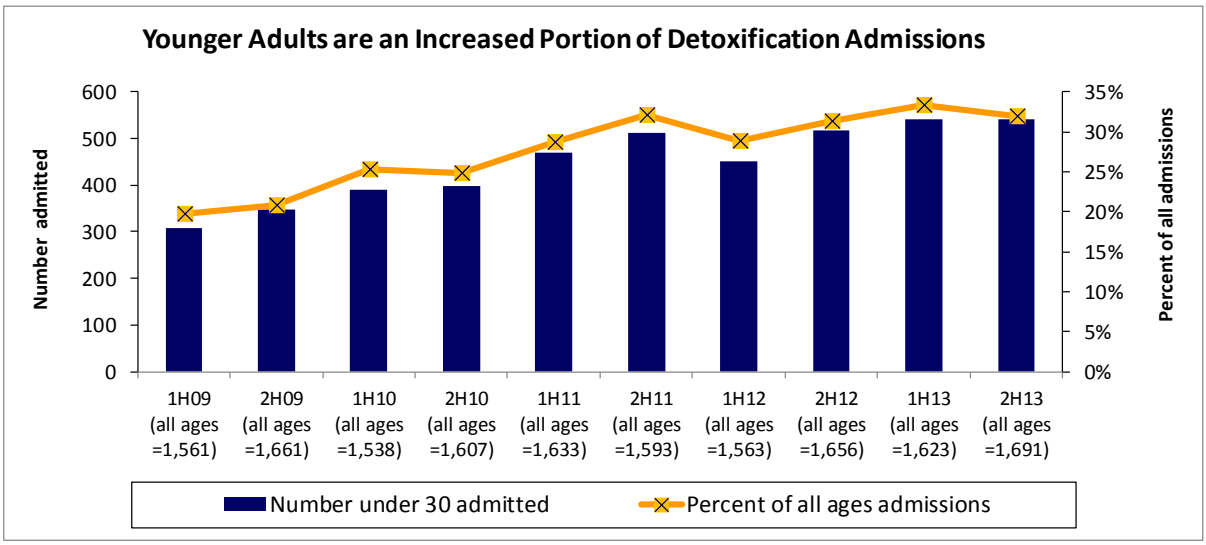
The table below shows data for the primary substance used by people admitted to different program areas and highlights differences among substances used.

Comparison of Primary Substance Used, January - December 2014

	Detoxification Center Admissions*	Outpatient Youth Admissions	Outpatient Adult Admissions
Total Number	3,174	1,035	8,064
Drug of Choice Percentage			
Alcohol	39%	13%	47%
Opiates	55%	2%	19%
Cocaine	2%	0%	8%
Methamphetamines	3%	4%	13%
Marijuana	0%	79%	12%
Other	0%	1%	2%

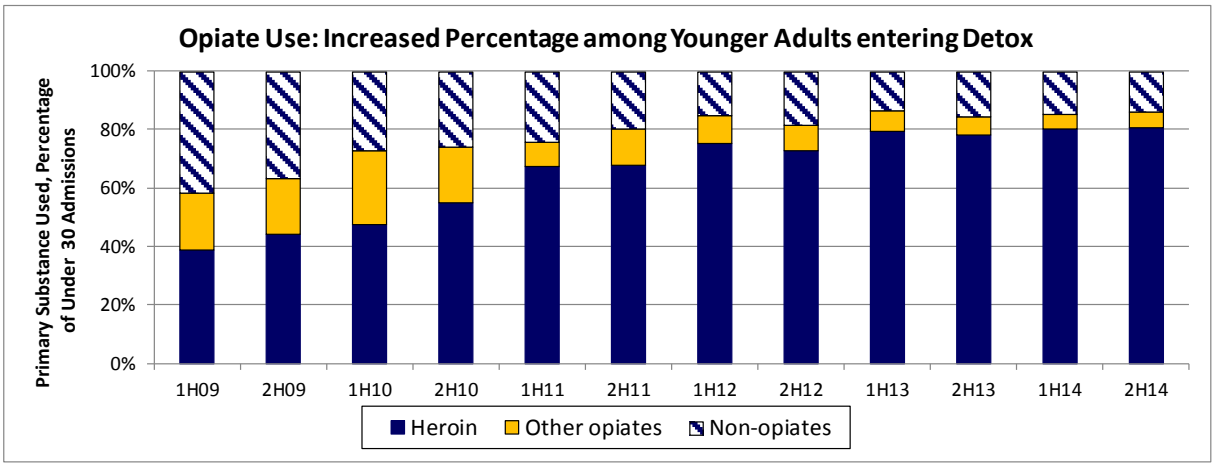
There is a dramatic difference between the Youth and Adult Outpatient identification of marijuana as the primary substance used.

As noted earlier, the percentage of people admitted for detoxification whose primary substance used is an opiate increased from 2009 through 2011 before leveling off in 2012, and the percentage using alcohol declined from 2009 through 2011. The change from 2009 through 2011 was driven by two factors shown in the following charts that also did not increase in 2012: an increase in the number and percentage of young adults under 30 years old entering detoxification services, and higher percentages of heroin or other opiate use among these detoxing young adults.

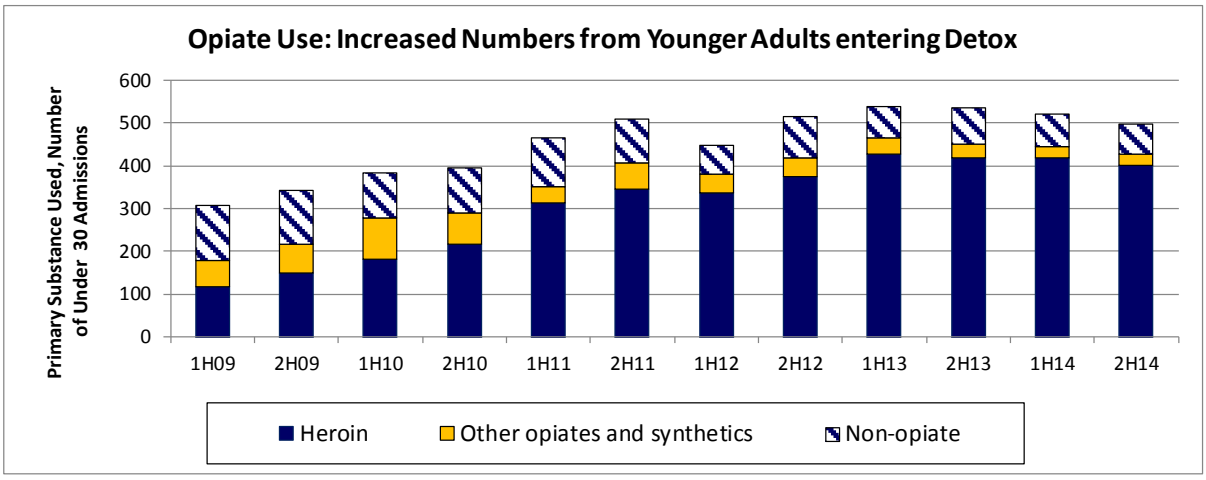


Because the total number of detoxification admissions each biennial quarter stays fairly constant, the number and percentage of young adults above had very similar increases across the five years from 2009 through 2013.

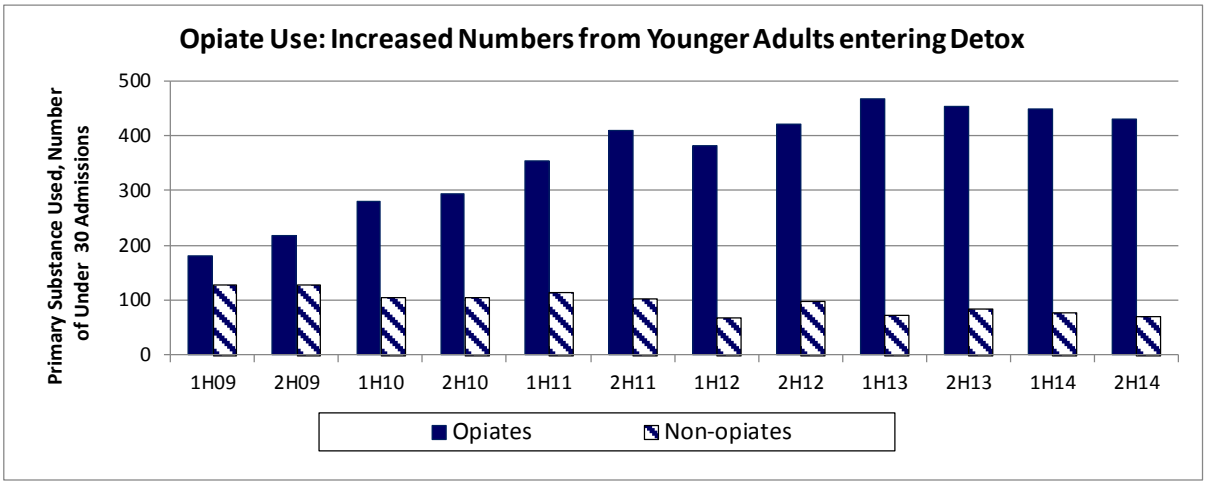
The following chart shows that, within the increased number of young adults seeking detoxification, a larger percentage is using opiates, with a more recent rise in heroin versus prescription opiates.



The following chart illustrates the compounded impact on the number of detoxification clients using opiates that has resulted from the increased percentage of younger adults in detoxification (first chart above) who are also more likely to use opiates (second chart above).



Here is another way to look at the impact of all opiate use by younger adults on detoxification admissions.



Although not as striking as the changes seen above in the use of opiates by those starting detoxification, there has been a small, continuing increase over this three-year report period in the use of opiates by adults in outpatient treatment (see the Adult Outpatient Treatment section). There has not been a clear increase in younger adults entering opioid treatment programs despite the significant increase in detoxing younger adults and opiate use within that group: the percentage of those less than 30 years old who were admitted to an OTP in the last six years has varied between 24 and 29 percent with no sustained trend. It may be that some of these younger adults are accessing doctor's office-based treatment using buprenorphine and/or naltrexone or that some are opting to attempt traditional outpatient "drug-free" treatment rather than medication-assisted treatment.

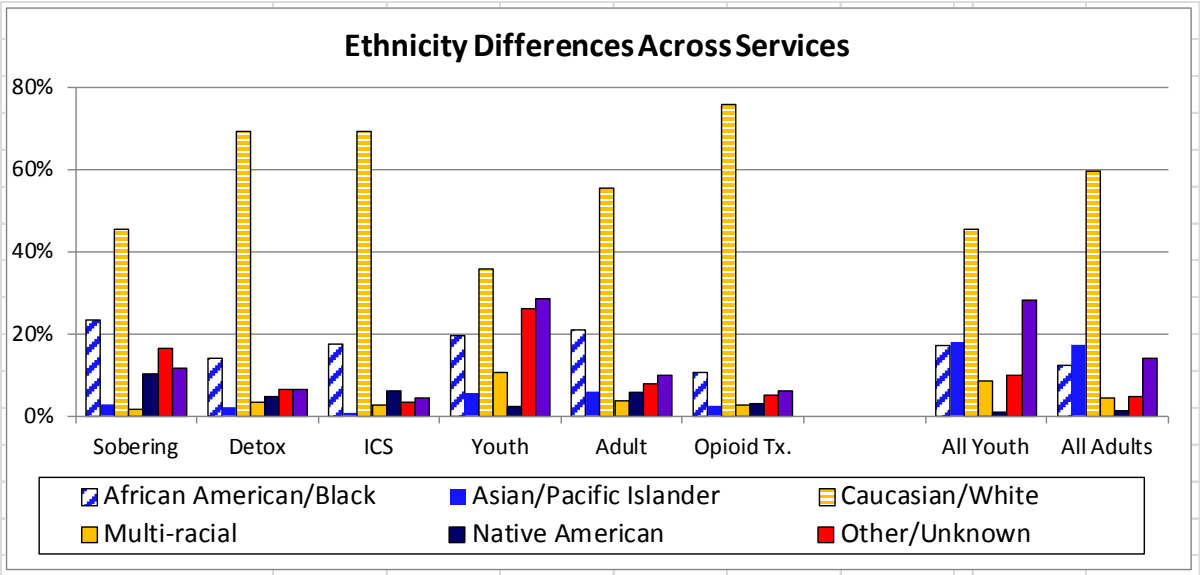
The opiate use data above are consistent with the "Seattle-King County Drug Trends 2013" report from the University of Washington, Alcohol and Drug Institute, which indicates that non-heroin/non-morphine opiates have been the leading cause of drug-related death in King County since 2005. The most recent data show a rise in heroin use and a dip in prescription opiate use.

Demographic Detail, January – December 2014

				Outpatient			King County Residents Below Fed. Pov. Level	
	Sobering	Detox	ICS	Youth	Adult	Opioid Tx.	Youth (12 - 17)	Adult (over 17)
Unduplicated people served	2,059	2,354	114	987	7,073	4,083	15,709	154,299
Gender								
Number of people								
Male	1,773	1,590	97	677	4,656	2,203	7,613	69,148
Female	268	764	17	310	2,417	1,880	8,096	85,151
Percent of all served								
Male	86%	68%	85%	69%	66%	54%	48%	45%
Female	13%	32%	15%	31%	34%	46%	52%	55%
("Unknown gender" counts are not included)								
Race/ethnic group:								
Number of people								
African American/Black	480	325	20	193	1,481	428	2,666	19,124
Asian/Pacific Islander	60	54		57	416	104	2,834	26,913
Caucasian/White	930	1,624	79	352	3,914	3,096	7,117	91,605
Multi-racial	36	82		105	269	118	1,350	6,705
Native American	213	117	7	23	425	132	182	2,354
Other/Unknown	340	152		257	568	205	1,560	7,598
Percent of all served								
African American/Black	23%	14%	18%	20%	21%	10%	17%	12%
Asian/Pacific Islander	3%	2%		6%	6%	3%	18%	17%
Caucasian/White	45%	69%	69%	36%	55%	76%	45%	59%
Multi-racial	2%	3%		11%	4%	3%	9%	4%
Native American	10%	5%	6%	2%	6%	3%	1%	2%
Other/Unknown	17%	6%		26%	8%	5%	10%	5%
	100%	100%	100%	100%	100%	100%	100%	100%
Hispanic origin:								
Number of people								
Hispanic origin	241	156	5	283	698	258	4,415	21,870
Not Hispanic origin/Unknown	1,818	2,198	109	704	6,375	3,825	11,294	132,429
Percent of all served								
Hispanic origin	12%	7%	4%	29%	10%	6%	28%	14%
Not Hispanic origin/Unknown	88%	93%	96%	71%	90%	94%	72%	86%
	100%	100%	100%	100%	100%	100%	100%	100%

(Percentages may not add up to 100% because of rounding. Counts under five are removed to protect confidentiality.)

The following is a combined view of the racial/ethnicity data shown above, showing the racial/ethnic distributions across services. There is considerable racial/ethnic variation across services.

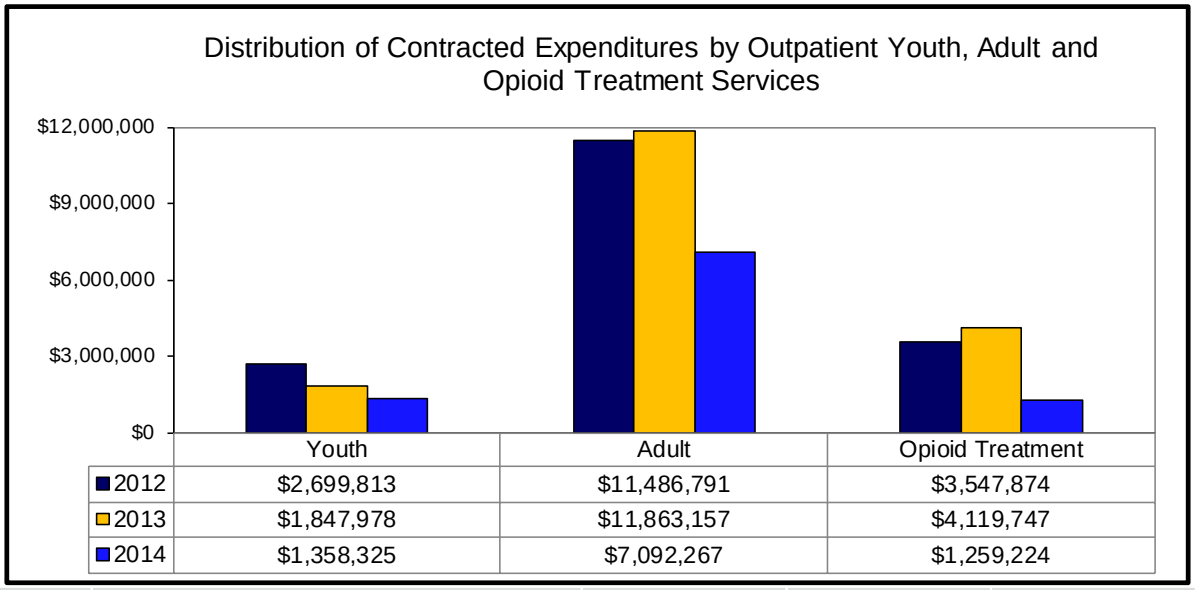


	Sobering	Detox	ICS	Youth	Adult	Opioid Tx.	All Youth	All Adults
African American/Black	**23%**	14%	18%	20%	21%	10%	**17%**	**12%**
Asian/Pacific Islander	3%	2%	1%	6%	6%	3%	**18%**	**17%**
Caucasian/White	**45%**	**69%**	69%	**36%**	55%	76%	**45%**	**59%**
Multi-racial	2%	3%	3%	11%	4%	3%	**9%**	**4%**
Native American	**10%**	**5%**	6%	2%	6%	3%	**1%**	**2%**
Other/Unknown	17%	6%	4%	**26%**	8%	5%	**10%**	**5%**
Hispanic origin	12%	**7%**	4%	29%	10%	6%	**28%**	**14%**

Financial Summary

King County Substance Abuse Fund
2012 - 2014 Actuals
Financial Plan

	2012 Actual	2013 Actual	2014 Actual
Beginning Fund Balance	**3,641,370**	**3,901,637**	**4,234,975**
Revenues			
Licenses & Permits	0	0	0
Federal Grants	2,583,140	7,001,280	4,116,879
State Grants	14,403,240	9,793,576	6,257,875
Intergovernment Payment	1,179,444	1,120,959	1,160,889
Charges for Services	597,692	506,711	505,563
Miscellaneous	21,157	13,512	(1)
Other Financing Sources			
Current Expense			
Total Revenues	**19,020,202**	**18,784,673**	**18,436,039**
Expenditures			
Administration	(1,789,867)	(1,944,478)	(1,557,017)
Housing Voucher Program *	0	0	0
Treatment	(15,982,895)	(15,208,711)	(9,523,544)
Prevention Activities	(678,573)	(1,208,044)	(838,963)
Total Expenditures	**(18,759,935)**	**(18,451,335)**	**(18,361,233)**
Other Fund Transactions			
Adjustment Prior Yr Expenditures		1,531	
DCFM Energy Surcharge Refund			
Total Other Fund Transactions			**1,531**
Ending Fund Balance	**3,901,637**	**4,234,975**	**4,311,312**



Appendices

Appendix A. Data Sources

This appendix describes the data sources used for the Substance Abuse Prevention and Treatment Annual Report and issues around the quality, meaning, and availability of the data. It also includes specific notes about the data presented for different program areas.

Data Sources

The data included in this report come from three broad types of sources:

- Summary data furnished by service providers. Such data are used for Emergency Services Patrol.
- A database developed by MHCADSD that is used by the Dutch Shisler Service Center and Involuntary Commitment Services to collect data for those programs.
- The State TARGET database that contains data from contracted providers about individuals and their treatment services. TARGET data are used for the Detoxification Center and Youth, Adult and Opioid Treatment Program outpatient treatment portions of this report. (Although the Sobering Support Center also submits data to the TARGET system, those data are not used in this report because only minimal TARGET data are collected for sobering services.)

Race/Ethnicity/Hispanic Origin Data Issues

Among the programs that are included in this report, there are a number of differences in how data about race, ethnicity, and Hispanic origin are collected and/or reported. To combine the data into a single consistent format, the following decisions were made:

- The "race/ethnicity" data reported for all program areas is presented using a single set of categories.
- The categories chosen are four commonly identified broad "race/ethnicity" groups (Black/African American, White/Caucasian/European American/Middle Eastern, Asian/Pacific Islander, and Native American/Alaska Native) and two other groups (Multi-racial and Other/Unknown).
- In those areas where the data collection system allowed more than one choice per person, any individual with data that "rolled up" into two or more different broad groups is counted as "Multi-racial" (White and Chinese, which rolled up to White and Asian-Pacific Islander, is counted as "Multi-racial"; Korean and Chinese as "Asian-Pacific Islander").
- "Other" is grouped with "Unknown" into "Other/Unknown."

Program-Specific Data Notes

Emergency Services Patrol
Individually identified data are not currently collected for this service.

Sobering Center (Dutch Shisler Service Center)
Data for services are entered into the MHCADSD chemical dependency database by sobering support center staff using the Sobering Center application.

Detoxification Center
Data for services at the Detoxification Center are entered into the TARGET data system by Detoxification Center staff. This report is based on downloaded data from that system.

A separate TARGET admission is reported for each level of care. To represent the true volume of admissions regardless of changes in level of care, only one admission is counted when a person had a prior TARGET detoxification admission that ended the day before the new TARGET admission date.

TARGET requires that data be reported about each person's "primary substance used" as reported by the person admitted and evaluated by the clinician. The Detoxification Center is not required to report data about the drug(s) for which the person is receiving detoxification services.

Involuntary Commitment Services
Data for Involuntary Commitment Services (ICS) referrals are entered into the integrated chemical dependency database by ICS staff using the ICS application. Data included are for referrals received and the disposition of referrals.

Outpatient Treatment: Youth, Adult, and Opioid Treatment Programs
Data for all Outpatient programs are entered into the TARGET system by service providers; the Substance Abuse Prevention and Treatment Annual Report is based on those data.

The data used in this report are limited as follows:

- Only admissions where the TARGET "Fund Source" is "County Community Services" or there was a King County "Special Project Code" at some time during the admission are included. These conditions include admissions funded by MIDD. Those data indicate that the services are provided under contracts with King County.

- Data included for Youth and Adult are for the TARGET modalities of intensive outpatient and outpatient. Data for Youth are for all admissions where the client was under 18 years old on the admission date (for Adult, 18 years or over).

- Data for Opioid Treatment Programs are for all admissions where the TARGET modality is "Methadone/Opiate Substitution Treatment."

- Opioid Treatment Program admissions that were essentially transfers to another treatment location (often with the same provider) were combined. Such continuous treatment episodes were counted as a new admission only for the period when the first admission started and were counted as only one admission for any period in which the combined admissions were open.

The treatment retention rate is based on all admissions that started during a report period. If the discharge date minus the admission date is greater than 90 days, or the admission has not yet ended (no discharge date), it is counted as retained 91 or more days. The count of those admissions each biennial quarter is divided by the count of all admissions that started in the biennial quarter to calculate the percentage shown. This algorithm is different from the DBHR measure that also uses treatment activity data and discharge reasons to categorize the admissions counted for a retention rate.

Appendix B. Glossary

ACA	Affordable Care Act
Biennial Quarter	Biennial quarters are one fourth of a biennium (two-year period), or six months long. Biennial quarters in this report are the first half of the calendar year and the second half of the calendar year.
Biennium	Washington State's fiscal year is organized on a two-year basis, referred to as a biennium. The last biennium included in this report began July 1, 2013 and will end June 30, 2015.
CD Tx	Chemical Dependency Treatment
CDP	Chemical Dependency Professional
CDPT	Chemical Dependency Professional Trainee
DBHR	Washington State Division of Behavioral Health and Recovery
ESP	Emergency Services Patrol
GAIN-SS	GAIN Short Screener. A quick tool used to screen for mental health and substance use diagnoses.
ICS	Involuntary Commitment Services (see program description)
MHCADSD	The Mental Health, Chemical Abuse and Dependency Services Division of the King County Department of Community and Human Services.
MIDD	The Mental Illness and Drug Dependency Action Plan is a King County initiative funded with a one tenth of one percent sales tax to provide programs designed to stabilize people suffering from mental illness and chemical dependency, and to divert them from jails and emergency rooms by getting them proper treatment.
OTP	Opioid treatment program (see program description)
PHSKC	Public Health – Seattle & King County
ROSC	Recovery-Oriented System of Care
SA	Substance Abuse
SUD	Substance Use Disorder
TARGET	Treatment Assessment and Report Generation Tool is a data collection and reporting system maintained by the Washington State Department of Social and Human Services and contains data submitted by contracted treatment providers about the publicly funded chemical dependency treatment that they provide.

Appendix C. Program Providers

Provider	Prev.	ESP	DSSC	Detox	ICS	Outpatient		OTP
						Youth	Adult	
Asian Counseling and Referral Service						x	x	
Auburn Youth Resources						x		
Catholic Community Services							x	
Center for Human Services						x	x	
Community Psychiatric Clinic						x	x	
Consejo Counseling and Referral Service						x	x	
Cowlitz Tribal Treatment						x		
Downtown Emergency Service Center							x	
Evergreen Manor							~~x~~	
Evergreen Treatment Services								x
Friends of Youth						x		
Harborview Medical Center Addictions Program							x	
Integrative Counseling Services						x	x	
Intercept Associates							x	
Kent Youth and Family Services						x		
King County Emergency Services Patrol		x						
King County Involuntary Commitment Services					x			
Muckleshoot Indian Tribe						x	x	
Navos	x					x	x	
Neighborhood House	x							
New Traditions							x	
Northshore Family and Youth Services						x		
Pioneer Human Services			x				x	
Recovery Centers of King County				x			x	
Renton Area Youth and Family Services						x		
SeaMar Community Health Centers						x	x	
Seattle Counseling Service						x	x	
Seattle Indian Health Board							x	
Seattle Public Schools	x							
Snoqualmie Indian Tribe						x	x	
Sound Mental Health						x	x	
Therapeutic Health Services						x	x	x
Valley Cities Counseling and Consultation						x	x	
Vashon Youth and Family Services	x					x	x	
WAPI Community Services						x		
Youth Eastside Services						x		